CENTER FOR HEALTH INFORMATION AND ANALYSIS

Data Specification Manual

957 CMR 2.00: Payer Reporting of Provider Payment Methods

August 4, 2014

957 CMR 2.00
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Data Specification Manual

Introduction

M.G.L. c. 12C, § 10 requires the Center for Health Information and Analysis ("Center") to collect from private and public health care payers "information on provider payment methods and levels" and "any applicable measures of provider performance in such alternative payment contracts."

Regulation 957 CMR 2.00 governs the methodology and filing requirements for health care payers to report this data to the Center. The Data Specification Manual provides additional technical details to assist payers in reporting and filing this data.

Payers are required to submit one Provider Payment Methods (PPM) filing to the Center annually. The file will contain hospital data for the previous calendar year, physician group data for the calendar year ending seventeen months prior, and other provider data for the previous calendar year. Files will contain different record types, including:

a. Payer Comments
b. Separate provider payment methods data with distinct lines for Medicare Advantage, Medicaid Managed Care, Commonwealth Care, and commercial by:
    - Acute hospital inpatient
    - Acute hospital outpatient
    - Psychiatric hospital inpatient, including behavioral health data for acute hospitals with psychiatric care or substance abuse units
    - Psychiatric hospital outpatient, including behavioral health data for acute hospitals with psychiatric care or substance abuse units
    - Chronic hospital inpatient
    - Chronic hospital outpatient
    - Rehabilitation hospital inpatient
    - Rehabilitation hospital outpatient
    - Physician group practices
    - Ambulatory surgical centers
    - Community health centers
    - Community mental health centers
    - Freestanding clinical labs
    - Freestanding diagnostic imaging
    - Home health agencies
    - Skilled nursing facilities

File Submission Instructions and Schedule

Payers will submit flat files with PPM data via INET. INET registration forms and submission instructions are available on the Center's website.
Payers will submit PPM data in accordance with regulation 957 CMR 2.00 on the following schedule:

Provider Payment Methods Filing Schedule	
Date	**File Due**
November 15, 2014	CY 2013 Hospital, Other Provider Payment Methods

	CY 2012 Physician Group Payment Methods

Data Submission

For the reporting of claims payments, payers shall report the total amount paid to Massachusetts providers, including claims data for non-Massachusetts members if they seek care at a Massachusetts provider. Payers shall exclude any paid claims for which it was the secondary or tertiary payer.

Payers shall report non-claims payments paid to each Massachusetts provider by insurance category and product type.

Payers shall classify payments made to each provider based on the member's associated payment method. If a member is under a global budget, and the global budget includes a visit to the hospital, then the hospital payments for that member shall be classified as global budget, even if the payment mechanism at the transactional level was fee-for-service. If a member is covered by a limited budget consisting only of primary care visits, but then visits a hospital, then the payments for that member to the hospital shall be classified based on how the payer pays the hospital since the member's limited budget did not include the hospital service.

Even though most alternative payment methods are layered on a fee-for-service structure, the overall settlement process at the end of the cycle determines the payment arrangement type for all of those dollars paid under the specific contract. For example, if a member is under a global payment contract, the dollar amount associated with this member should be classified as a global payment method even though the payer utilizes a fee-for-service payment mechanism to reimburse providers at the transactional level. The same logic applies to limited budget or bundled payment arrangements. The dollars reported for limited budget or bundled payment arrangements shall include all dollar amounts paid for members associated with the contract, even if a fee-for-service mechanism was used for claims processing and payment transaction purposes.

Reporting Thresholds

For hospital inpatient and hospital outpatient reporting, payers shall report all Massachusetts hospitals as listed on the Center's OrgID list.

For physician group reporting, payers shall report the provider payment methods for the top 30 physician groups based on revenue by insurance category. Payers shall report all remaining physician groups in aggregate, using OrgID 999996.

For other provider reporting, payers shall report the provider payment methods for the providers who receive 3% or more of a payer's revenue within each provider type and insurance category.

Field Definitions: Hospital Inpatient and Hospital Outpatient

Hospital OrgID: The Organizational ID assigned by the Center for each hospital. Hospital OrgIDs may be found in Appendix A.

Hospital Type Code: A number that indicates the reported hospital type. Please refer to Appendix A for a list of Massachusetts hospitals by hospital type.

Hospital Type Code	Definition
1	**Acute Hospital**
2	**Psychiatric or Substance Abuse Hospital or Acute Hospital Behavioral Health Only**
3	**Chronic Hospital**
4	**Rehabilitation Hospital**

Insurance Category Code: A number that indicates the reported insurance category.

Insurance Category Code	Definition
1	**Medicare & Medicare Advantage**
2	**Medicaid & Medicaid MCO**
3	**Commonwealth Care**
4	**Commercial**
5	**Dual-Eligibles, 65 and over**
6	**Dual-Eligibles, 21-64**
7	**Other (MSP, SCO, PACE, Bridge)**

Product Type: The product type under the insurance category reported.

Product Type Code	Definition
1	**HMO and POS**
2	**PPO**
3	**Indemnity**
4	**Other**

Payment Method: Payments will be reported by payment method, as defined below.

Global Budget/Payment: Payment arrangements where budgets for health care spending are set either prospectively or retrospectively for a comprehensive set of services for a broadly defined population. Contract must include at a minimum: physician services and inpatient and outpatient hospital services. Examples include shared savings and full/partial risk arrangements.

Limited Budget: Payment arrangements where budgets for health care spending are set either prospectively or retrospectively for a non-comprehensive set of services to be delivered by a single provider organization (such as capitated primary care and oncology services).

Bundled Payments: Fixed dollar payments for the care that patients may receive in a given episode of care for a specific condition delivered by multiple provider types.

Other, non-FFS based: All other payment arrangements not based on a fee-for-service model, including supplemental payments for the Patient Center Medical Home Initiative (PCHMI).

Fee for Service (FFS): A payment mechanism in which all reimbursable health care activity is described and categorized into discreet and separate units of service and each provider is separately reimbursed for each discrete service rendered to a patient. Fee for service payment includes: Diagnosis Related Groups (DRGs), per-diem payments, fixed procedure code-based fee schedule (e.g. Medicare's Ambulatory Payment Classifications (APCs)), claims-based payments adjusted by performance measures, and discounted charges-based payments. This category also includes Pay for Performance incentives that accompany FFS payments.

Carve-Out Services: Payments made to a third party administrator that covers the costs of a specific category of expenses, such as behavioral health or prescription drugs. Payments shall be classified as carve-out services only if the payer is unable to obtain the payment mechanism used by the carve-out vendor to pay the provider according to the vendor's contractual relationship with the provider.

Payment Method Code	Definition
1	**Global Budget/Payment**
2	**Limited Budget**
3	**Bundled Payments**
4	**Other, non-FFS based**
5	**Fee for Service**
6	**Carve-Out Services**

Total Claims Payments: The sum of all associated claims payments, including patient cost sharing amounts, for each insurance category, product type, and payment method combination.

Total Non-Claims Payments: The sum of all associated non-claims payments for each insurance category, product type, and payment method combination.

Total Payments: The sum of Total Claims Payments and Total Non-Claims Payments.

Amount of Total Payments due to Financial Performance Measures: The subset dollar amount of the total payments paid for financial performance-based contracts for each insurance category, product type, and payment method combination. A financial performance payment is defined as additions to the base payment or adjustments to a contracted payment amount made based solely on the achievement of financial or cost-based measures.

Amount of Total Payments due to Quality Performance Measures: The subset dollar amount of the total payments paid for quality performance-based contracts, for each insurance category, product type and payment method combination. A quality performance payment is made either as an addition to the base payment or as an adjustment to a contracted payment amount, in both cases to reward a provider for quality, access and/or patient experience. Quality performance-based contracts do not include contracts that incorporate payment adjustments based solely on provider cost or efficiency performance.

Amount of Total Payments due to Financial and Quality Performance Measures Combined: The subset dollar amount of the total payments paid for combined financial and quality performance-based contracts, for each insurance category, product type and payment method combination. These include contracts that incorporate payment adjustments based on linked financial and quality performance measures.

Field Definitions: Physician Group and Other Providers

Parent Physician Group/Other Provider OrgID: The OrgID assigned by the Center for the parent physician group. For Other Provider reporting, this will be the OrgID assigned by the Center for the provider. Refer to Appendix A for the number associated with the parent physician group or other provider group.

Local Practice Group/Other Provider OrgID: The OrgID assigned by the Center for the local practice group. For Other Provider reporting, this will be the OrgID assigned by the Center for the provider. Please note that the OrgID for an Other Provider will be the same as the OrgID reported in the aforementioned field. Refer to Appendix A for the number associated with the Local Practice Group or other provider group.

Organization Type: For Other Provider reporting only, the type of organization being reported.

Organization Type Code	Definition
3	**Ambulatory Surgical Center**
4	**Community Health Center**
5	**Community Mental Health Center**
6	**Freestanding Clinical Labs**
7	**Freestanding Diagnostic Imaging**
8	**Home Health Agency**
9	**Skilled Nursing Facility**

Insurance Category Code: A number that indicates the reported insurance category.

Insurance Category Code	Definition
1	Medicare & Medicare Advantage
2	Medicaid & Medicaid MCO
3	Commonwealth Care
4	Commercial
5	Dual-Eligibles, 65 and over
6	Dual-Eligibles, 21-64
7	Other (MSP, SCO, PACE, Bridge)

Product Type: The product type under the insurance category reported.

Product Type Code	Definition
1	HMO and POS
2	PPO
3	Indemnity
4	Other

Payment Method: Payments will be reported by payment method, as defined below.

Global Budget/Payment: Payment arrangements where budgets for health care spending are set either prospectively or retrospectively for a comprehensive set of services for a broadly defined population. Contract must include at a minimum: physician services and inpatient and outpatient hospital services. Examples include shared savings and full/partial risk arrangements.

Limited Budget: Payment arrangements where budgets for health care spending are set either prospectively or retrospectively for a non-comprehensive set of services to be delivered by a single provider organization (such as capitated primary care and oncology services).

Bundled Payments: Fixed dollar payments for the care that patients may receive in a given episode of care for a specific condition delivered by multiple provider types.

Other, non-FFS based: All other payment arrangements not based on a fee-for-service model, including supplemental payments for the Patient Center Medical Home Initiative (PCHMI).

Fee for Service: A payment mechanism in which all reimbursable health care activity is described and categorized into discreet and separate units of service and each provider is separately reimbursed for each discrete service rendered to a patient. Fee for service payment includes: DRGs, per-diem payments, fixed procedure code-based fee schedule (e.g. Medicare's APCs), claims-based payments adjusted by performance measures, and discounted charges-based payments.

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Payment Method Code	Definition
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Amount of Total Payments due to Financial and Quality Performance Measures Combined: The subset dollar amount of the total payments paid for combined financial and quality performance-based contracts, for each insurance category, product type and payment method combination. These include contracts that incorporate payment adjustments based on linked financial and quality performance measures.

For detailed information on data submission, please see Appendix B.

Appendix A. Provider OrgIDs

Please visit:

http://www.mass.gov/chia/researcher/hcf-data-resources/payer-data-reporting/total-medical-expenses-filing-information.html

Appendix B. Data Submission Guidelines

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
HD-PPM	1	HD001	Header Record Identifier	01/24/14	Text	Text	2	Yes	This must have HD reported here. Indicates the beginning of the Header Record. Note: Every File must contain on HD record.
HD-PPM	2	HD002	Payer	01/24/14	Integer	########	8	Yes	This is the Carriers ORG ID. This must match the Submitters ORG ID.
HD-PPM	3	HD003	National Plan ID	01/24/14	Text		30	No	Unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans.
HD-PPM	4	HD004	Type of File	01/24/14	Integer	####	4	Yes	This must have 148 reported here. This is an indicator that defines the type of file and the data contained within the file.
HD-PPM	5	HD005	Period Beginning Date	01/24/14	Date Period	MMDDYYYY Or MM/DD/YYYY	10	Yes	This is the start date period of the reported period in the submission file.
HD-PPM	6	HD006	Period Ending Date	01/24/14	Date Period	MMDDYYYY Or MM/DD/YYYY	10	Yes	This is the end date period of the reported period in the submission file; if the period reported is a single month of the same year then Period Begin Date and Period End Date will be the same date.
HD-PPM	7	HD007	Hospital Inpatient Record Count	01/24/14	Integer	#	10	Yes	Record Count for Provider Payment Methods for Hospital Inpatient
HD-PPM	8	HD008	Hospital Outpatient Record Count	01/24/14	Integer	#	10	Yes	Record Count for Provider Payment Methods for Hospital Outpatient
HD-PPM	9	HD009	Provider Record Count	01/24/14	Integer	#	10	Yes	Record Count for Provider Payment Methods for Provider

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
HD-PPM	10	HD010	PPM Comments	01/24/14	Text	Text	500	No	Use this field to provide any additional information or to describe any data caveats for the PPM data submission.
HD-PPM	11	HD011	Additional Comments	01/24/14	Text	Text	500	No	Payers may use this field to provide any additional information or comments regarding the submissions.
HD-PPM	12	HD012	File Type	01/24/14	Text	Text	3	Yes	Type of PPM File HOS = Hospital PG = Physician Group OP = Other Provider
HD-PPM	13	HD013	Submission Type	01/24/14	Text	Flag	1	Yes	Type of Submission file T= Test P = Production
HI	1	HI001	PPM Record Type ID	01/24/14	Text	Text	3	Yes	This must have an HI reported here. Indicates the beginning of the Hospital Inpatient PPM record.
HI	2	HI002	Hospital OrgID	01/24/14	Integer	######	6	Yes	OrgID assigned by the CHIA for each hospital. Must be a CHIA-issued OrgID.
HI	3	HI003	Hospital Type Code	01/24/14	Integer	#	1	Yes	Indicates the Hospital type that is being reported : 1 = Acute Hospital 2 = Psychiatric Hospital/ Behavioral Health Unit 3 = Chronic Hospital 4 = Rehabilitation Hospital Value must be an integer between '1' and '4'.
HI	4	HI004	Insurance Category Code	01/24/14	Integer	#	1	Yes	Indicates the insurance category that is being reported : 1 = Medicare & Medicare Advantage 2 = Medicaid & Medicaid MCO 3 = Commonwealth Care

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
									4 = Commercial 5 = Dual-Eligibles, 65 and over 6 = Dual-Eligibles, 21~~18~~-64 7 = Other (MSP, SCO, PACE, Bridge) Values must be an integer between '1' and '7'.
HI	5	HI005	Product Type Code	01/24/14	Integer	#	1	Yes	Indicates the product type that is being reported : 1 = HMO and POS 2 = PPO 3 = Indemnity 4 = Other (e.g. EPO) Values must be an integer between '1' and '4'.
HI	6	HI006	Payment Method Code	01/24/14	Integer	#	1	Yes	Indicates the payment method being reported: 1 = Global Budget/Payment 2 = Limited Budget 3 = Bundled Payments 4 = Other, non-FFS Based (e.g. PCHMI) 5 = Fee-For-Service 6 = Carve-Out Services Values must be an integer between '1' and '6'.
HI	7	HI007	Total Claims Payments	01/24/14	Money	##.##	12	Yes	The sum of all associated medical claims payments made to each provider for each insurance category, product type, and payment method combination. No negative values.
HI	8	HI008	Total Non-Claims Payments	01/24/14	Money	##.##	12	Yes	Total of all non-claims payments. The sum of all associated non-claims payments made to each provider for each insurance category, product type, and payment method combination.

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
HI	9	HI009	Total Payments	01/24/14	Money	##.##	12	Yes	The sum of Total Claims Payments and Total Non-Claims Payments. No negative values.
HI	10	HI010	Amount of Total Payments due to Financial Performance Measures	01/24/14	Money	##.##	12	Yes	The subset dollar amount of the total payments paid for financial performance-based contracts for each insurance category, product type, and payment method combination
HI	11	HI011	Payments due to Quality Measures	01/24/14	Money	##.##	12	Yes	The subset dollar amount of the total payments paid for quality performance-based contracts, for each insurance category, product type and payment method combination
HI	12	HI012	Total Payments due to Financial and Quality Performance Measures Combined	01/24/14	Money	##.##	12	Yes	The subset dollar amount of the total payments paid for combined financial and quality performance-based contracts, for each insurance category, product type and payment method combination These include contracts that incorporate payment adjustments based on linked financial and quality performance
HO	1	HI001	PPM Record Type ID	01/24/14	Text	Text	3	Yes	This must have an HO reported here. Indicates the beginning of the Hospital Inpatient PPM record.
HO	2	HO002	Hospital OrgID	01/24/14	Integer	######	6	Yes	OrgID assigned by the CHIA for each hospital. Must be a CHIA-issued OrgID.
HO	3	HO003	Hospital Type	01/24/14	Integer	#	1	Yes	Indicates the Hospital type that is being reported : 1 = Acute Hospital 2 = Psychiatric Hospital/ Behavioral

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
									Health Unit 3 = Chronic Hospital 4 = Rehabilitation Hospital Values must be an integer between '1' and '4'.
HO	4	HO004	Insurance Category Code	01/24/14	Integer	#	1	Yes	Indicates the insurance category that is being reported : 1 = Medicare & Medicare Advantage 2 = Medicaid & Medicaid MCO 3 = Commonwealth Care 4 = Commercial 5 = Dual-Eligibles, 65 and over 6 = Dual-Eligibles, 2118-64 7 = Other (MSP, SCO, PACE, Bridge) Values must be an integer between '1 and '7'.
HO	5	HO005	Product Type Code	01/24/14	Integer	#	1	Yes	Indicates the product type that is being reported : 1 = HMO and POS 2 = PPO 3 = Indemnity 4 = Other (e.g. EPO) Values must be an integer between '1' and '4'.
HO	6	HO006	Payment Method Code	01/24/14	Integer	#	1	Yes	Indicates the payment method being reported: 1 = Global Budget/Payment 2 = Limited Budget 3 = Bundled Payments 4 = Other, non-FFS Based (e.g. PCHMI) 5 = Fee-For-Service 6 = Carve-Out Services Values must be an integer between '1'

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
									and '6'.
HO	7	HO007	Total Claims Payments	01/24/14	Money	##.##	12	Yes	The sum of all associated medical claims payments made to each provider for each insurance category, product type, and payment method combination. No negative values.
HO	8	HO008	Total Non-Claims Payments	01/24/14	Money	##.##	12	Yes	Total of all non-claims payments. The sum of all associated non-claims payments made to each provider for each insurance category, product type, and payment method combination.
HO	9	HO009	Total Payments	01/24/14	Money	##.##	12	Yes	The sum of Total Claims Payments and Total Non-Claims Payments. No negative values.
HO	10	HO010	Amount of Total Payments due to Financial Performance Measures	01/24/14	Money	##.##	12	Yes	The subset dollar amount of the total payments paid for financial performance-based contracts for each insurance category, product type, and payment method combination
HO	11	HO011	Payments due to Quality Measures	01/24/14	Money	##.##	12	Yes	The subset dollar amount of the total payments paid for quality performance-based contracts, for each insurance category, product type and payment method combination
HO	12	HO012	Total Payments due to Financial and Quality Performance Measures Combined	01/24/14	Money	##.##	12	Yes	The subset dollar amount of the total payments paid for combined financial and quality performance-based contracts, for each insurance category, product type and payment method combination These include contracts that incorporate payment adjustments based on linked financial and quality performance

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
PG	1	PG001	PPM Record Type	01/24/14	Text	Text	2	Yes	This must have PG reported here. Indicates the beginning of the Provider based PPM record
PG	2	PG002	Parent Physician Group OrgID	01/24/14	Integer	######	6	Yes	For aggregation of all other sites that fall below the threshold and that do not belong to a larger parent organization, use ORGID 999996. Note: If PG002=999996, then PG003 must also equal 999996 Must be a CHIA-issued OrgID
PG	3	PG003	Local Practice Group OrgID	01/24/14	Integer	######	6	Yes	Local Practice Group OrgID For aggregation of sites that fall below threshold, but that are part of a larger parent organization, use ORGID 999997 Note: If PG002=999996, then PG003 must also equal 999996 Must be a CHIA-issued OrgID.
PG	4	PG004	Insurance Category Code	01/24/14	Integer	#	1	Yes	Indicates the insurance category that is being reported : 1 = Medicare & Medicare Advantage 2 = Medicaid & Medicaid MCO 3 = Commonwealth Care 4 = Commercial 5 = Dual-Eligibles, 65 and over 6 = Dual-Eligibles, 2118-64 7 = Other (MSP, SCO, PACE, Bridge) Values must be an integer between '1 and '7'.
PG	5	PG005	Product Type Code	01/24/14	Integer	#	1	Yes	Indicates the product type that is being reported : 1 = HMO and POS

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
									2 = PPO 3 = Indemnity 4 = Other (e.g. EPO) Values must be an integer between '1' and '4'.
PG	6	PG006	Payment Method Code	01/24/14	Integer	#	1	Yes	Indicates the payment method being reported: 1 = Global Budget/Payment 2 = Limited Budget 3 = Bundled Payments 4 = Other, non-FFS Based (e.g. PCHMI) 5 = Fee-For-Service 6 = Carve-Out Services Values must be an integer between '1' and '6'.
PG	7	PG007	Total Claims Payments	01/24/14	Money	##.##	12	Yes	The sum of all associated medical claims payments made to each provider for each insurance category, product type, and payment method combination. No negative values.
PG	8	PG008	Total Non-Claims Payments	01/24/14	Money	##.##	12	Yes	Total of all non-claims payments. The sum of all associated non-claims payments made to each provider for each insurance category, product type, and payment method combination.
PG	9	PG009	Total Payments	01/24/14	Money	##.##	12	Yes	The sum of Total Claims Payments and Total Non-Claims Payments. No negative values.
PG	10	PG010	Amount of Total Payments due to Financial Performance Measures	01/24/14	Money	##.##	12	Yes	The subset dollar amount of the total payments paid for financial performance-based contracts for each insurance category, product type, and payment method combination

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
PG	11	PG011	Payments due to Quality Performance Measures	01/24/14	Money	##.##	12	Yes	The subset dollar amount of the total payments paid for quality performance-based contracts, for each insurance category, product type and payment method combination
PG	12	PG012	Total Payments due to Financial and Quality Performance Measures Combined	01/24/14	Money	##.##	12	Yes	The subset dollar amount of the total payments paid for combined financial and quality performance-based contracts, for each insurance category, product type and payment method combination These include contracts that incorporate payment adjustments based on linked financial and quality performance
				01/24/14					
OP	1	OP001	PPM Record Type	01/24/14	Text	Text	2	Yes	This must have OP reported here. Indicates the beginning of the Provider based PPM record
OP	2	OP002	Other Provider OrgID	01/24/14	Integer	######	6	Yes	Must be a CHIA-issued OrgID for each provider.
OP	3	OP003	Organization Type	01/24/14	Integer	#	1	Yes	Other provider type, must be one of the following: 3 = Ambulatory Surgical Center 4 = Community Health Center 5 = Community Mental Health Center 6 = Freestanding Clinical Labs 7 = Freestanding Diagnostic Imaging 8= Home Health Agency 9 = Skilled Nursing Facility Value must be an integer between ‘3’ and ‘9’.

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
OP	4	OP004	Insurance Category Code	01/24/14	Integer	#	1	Yes	Indicates the insurance category that is being reported : 1 = Medicare & Medicare Advantage 2 = Medicaid & Medicaid MCO 3 = Commonwealth Care 4 = Commercial 5 = Dual-Eligibles, 65 and over 6 = Dual-Eligibles, 2118-64 7 = Other (MSP, SCO, PACE, Bridge) Values must be an integer between '1 and '7'.
OP	5	OP005	Product Type Code	01/24/14	Integer	#	1	Yes	Indicates the product type that is being reported : 1 = HMO and POS 2 = PPO 3 = Indemnity 4 = Other (e.g. EPO) Values must be an integer between '1' and '4'.
OP	6	OP006	Payment Method Code	01/24/14	Integer	#	1	Yes	Indicates the payment method being reported: 1 = Global Budget/Payment 2 = Limited Budget 3 = Bundled Payments 4 = Other, non-FFS Based (e.g. PCHMI) 5 = Fee-For-Service 6 = Carve-Out Services Values must be an integer between '1' and '6'.
OP	7	OP007	Total Claims Payments	01/24/14	Money	##.##	12	Yes	The sum of all associated medical claims payments made to each provider for each insurance category, product type, and payment method combination. No negative values.

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
OP	8	OP008	Total Non-Claims Payments	01/24/14	Money	##.##	12	Yes	Total of all non-claims payments. The sum of all associated non-claims payments made to each provider for each insurance category, product type, and payment method combination.
OP	9	OP009	Total Payments	01/24/14	Money	##.##	12	Yes	The sum of Total Claims Payments and Total Non-Claims Payments. No negative values.
OP	10	OP010	Amount of Total Payments due to Financial Performance Measures	01/24/14	Money	##.##	12	Yes	The subset dollar amount of the total payments paid for financial performance-based contracts for each insurance category, product type, and payment method combination
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Table A. Insurance Category

ID	Description
1	Medicare and Medicare Advantage
2	Medicaid and Medicaid MCO
3	Commonwealth Care
4	Commercial
5	Dual-Eligibles, 65 and over
6	Dual-Eligibles, 21-64
7	Other (MSP, SCO, PACE, Bridge)

Table B. Product Type

ID	Description
1	HMO and POS
2	PPO
3	Indemnity
4	Other (e.g. EPO)

Table C. Payment Method

ID	Description
1	Global Budget/Payment
2	Limited Budget
3	Bundled Payments
4	Other, non-FFS based (e.g. PCMHI)
5	Fee For Service
6	Carve-Out Services

Table D. Hospital Type

ID	Description
1	Acute Hospital
2	Psychiatric or Substance Abuse Hospital or Acute Hospital Behavioral Health Only

3	Chronic Hospital
4	Rehabilitation Hospital

Table E. Other Provider Type

ID	Description
3	Ambulatory Surgical Center
4	Community Health Center
5	Community Mental Health Center
6	Freestanding Clinical Labs
7	Freestanding Diagnostic Imaging
8	Home Health Agency
9	Skilled Nursing Facility

File Submission Naming Conventions

Chapter 224 data submissions should follow the following naming conventions:

SubmissionType_YYYY_Version.dat,

Where Submission Type is one of the following:

PPM224 for Chapter 224 Provider Payment Methods data submissions

YYYY is the four digit year

Version is **optional**, and indicates the submission number.

The file extension must be .dat (or .DAT)

Below are examples of validly named files:

PPM224_2014_01.dat or ppm224_2014_1.dat or ppm224_2014.dat